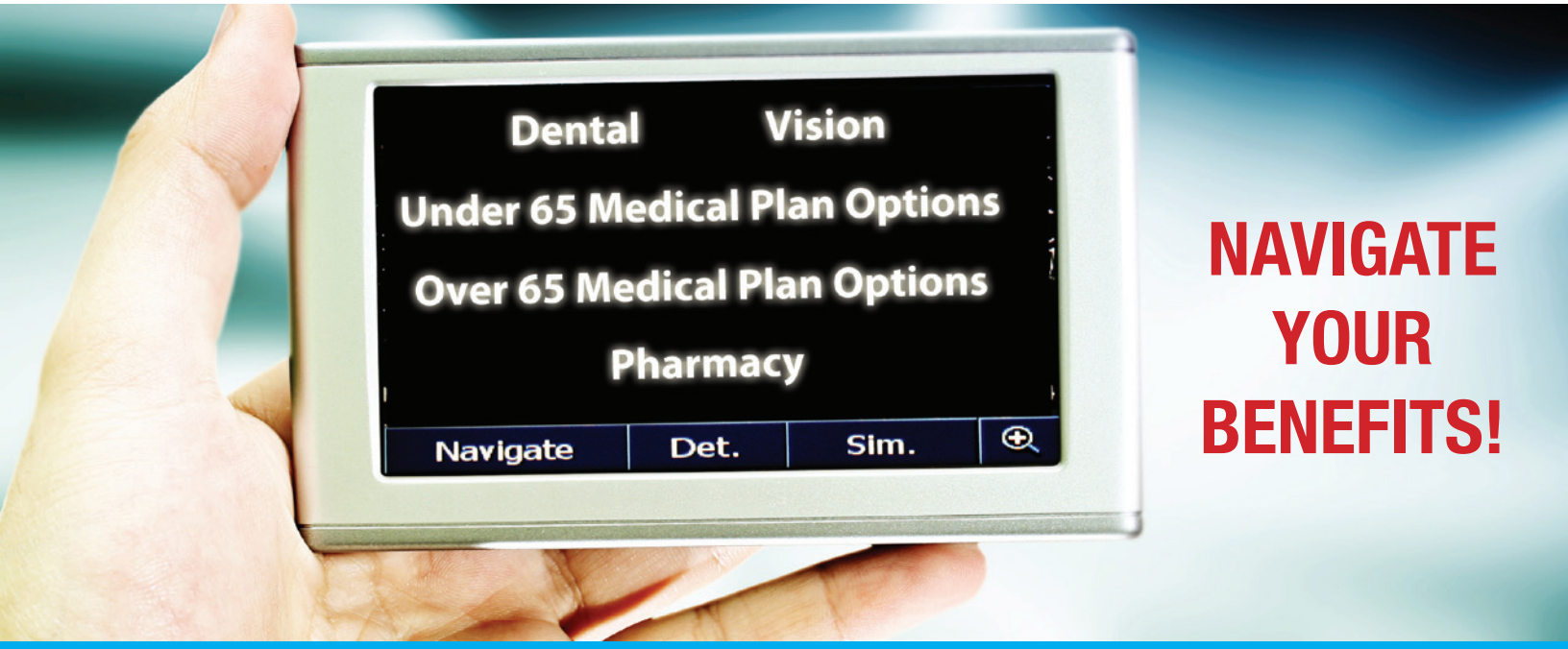
2013 Retiree Benefit Guide



NAVIGATE YOUR BENEFITS!

ARLINGTON®

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As a retiree with the City of Arlington, you have a number of important benefit decisions to make within 30 days of your retirement and annually thereafter. This booklet includes retiree benefit plan information. Additional resources are available on the City website www.arlingtontx.gov. Select the **City Programs/Services** drop down box on the upper left side of City website. Then select **Retirees**. Next select **City Benefits**.

REQUIRED NOTICES:

Warning:

Any intentional false statement in your enrollment or willful misrepresentation relative thereto is subject to financial restitution and/or cancellation of coverage.

2013 Benefit Plan Updates

This Benefit Guide highlights recent plan design changes and is intended to provide you with a Summary of Material Modifications. **In 2013, the City will Incorporate the following plan modifications:**

A. Under Age 65 Medical Plans

1. The Annual Deductible for the Core & Plus Medical Plans will go toward meeting the annual out-of-pocket maximum.
2. The annual out of pocket maximum for the Core & Plus Medical Plan will be $5,000 individual and $10,000 family.
3. The pre-exisiting exclusion clause for adults has been removed (this exclusion was removed for children effective 1/1/2012).
4. Additional preventive services will be covered at 100% when they are delivered by an in-network provider and they are included as eligible by the U.S. Preventive Services Task Force
5. Bariatric surgery will be limited to one procedure per lifetime. This limit includes when a procedure doesn't work and another procedure Is recommended by your physician. Example: have bypass surgery and then physician recommends lap band - the lap band surgery would not be considered an eligible expense under the plan.
6. A Summary of Benefits and Coverage (SBC), which summarizes important information about the health plan coverage options is available on the City website www.arlingtontx.gov under Retiree benefits, or your may request a paper copy free by calling 817.459.6869.

B. Prescription Plan

Effective 1/1/2013 the plan will provide 100% coverage for eligible contraception when delivered by an in-network provider and they are included as eligible by the U.S. Preventive Services Task Force.

C. Flexible Spending Account

The IRS has established a $2,500 annual maximum for Health & Limited Scope FSA accounts effective 1/1/2013. NOTE: Any roll over funds remaining in your FSA account on 12/31/1012 will not count toward your 2013 election.

Initial Notice of Your HIPAA Special Enrollment Rights

Loss of Other Coverage - If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. **You will be required to submit a signed statement that this other coverage was the reason for waiving enrollment originally.** To be eligible for this special enrollment opportunity you must request enrollment within 30 days after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption - If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Medicaid Coverage - The City of Arlington group health plan will allow a retiree or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. TERMINATION OF MEDICAID OR CHIP COVERAGE- If the retiree or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the retiree or dependent under such a plan is terminated as a result of loss of eligibility.
2. ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP- If the retiree or dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assis-tance for their employer's group health plan rather than provide direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the retiree or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

Note: The 60 day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30 day period applies to most special enrollments.

To request special enrollment or obtain more information, contact Workforce Services at 817.459.6869. Also refer to "Life Changes Requiring Health Choices…Know Your Benefit Options" on page 15 for additional information.

Retiree Eligibility

The following criteria must be met in order to enroll in the benefit plans described in this guide:

1. Eligible for retirement with the Texas Municipal Retirement System (TMRS) at the time Retiree left employment with the City of Arlington and a minimum of 10 years of eligible service with the City of Arlington; or
2. Retired from the City of Arlington and have a minimum 10 years of eligible service with the City of Arlington.

New Retirees: When eligible, you are required to enroll no later than 30 days after your retirement. If enrollment is not completed within this time period, no coverage will be available for the remainder of the plan year.

Social Security Number Requirement

Effective immediately, the Centers for Medicare and Medicaid requires the City of Arlington obtain the Social Security number (SSN) for all family members enrolled in City benefits. Enrollments will only be accepted if a Social Security number is provided for each family member.

Medicare Card Requirement

The Centers for Medicare and Medicaid have established coverage rules to determine which plan is considered primary and secondary when you or a family member becomes eligible for Medicare. Eligibility may be due to a disability prior to age 65 and/or attainment of age 65.

It is the retiree's responsibility to notify Workforce Services of an individual's eligibility for Medicare. **You are required to provide a copy of the Medicare card for all family members who are eligible or who become eligible while you are employed or retired when you are enrolled in any City benefit plan.**

What happens to my coverage when I become 65: Medical and pharmacy coverage in the Value, Core or Plus and Pharmacy Plan will end the last day of the month prior to the month you become age 65.

Medicare Supplement Plans: Participants age 65 and over who wish to remain on a City of Arlington health plan must enroll in either the UHC Medicare Advantage HMO Plan (previously Secure Horizons) which includes pharmacy coverage or an AARP Medicare Supplement option with or without separate pharmacy coverage. In order to be eligible to enroll in one of the Medicare Supplement AARP options or the UHC Medicare Advantage HMO plan offered by the City, you must be enrolled in both Medicare Part A and Part B.

The Retiree Benefit Election form and information on the Age 65 + Plan options are located on the City website at www.arlingtontx.gov on the Retirees section of the website. In order to be enrolled in any Age 65+ Plan, you must complete the UHC Medicare Advantage HMO or AARP Supplement Plan enrollment form and mail it to the address indicated on the form. You must also complete the City of Arlington 2013 Retiree Benefit Election Form and return to the City. The City is not authorized to enroll, change, or drop coverage in these plans for you. **Contact Workforce Services 90 days prior to you or your family member's attainment of age 65.**

Dependent Eligibility

Who is considered an eligible dependent?

Eligible Dependents	Documentation Required for Enrollment	Due Dates
Spouse	• Marriage License • Most Recent Joint Tax Return • Informal Marriage Form	30 days
*Child / Stepchild	• Birth Certificate	30 days
*Other Dependent Child	• Court order for Guardianship or Conservatorship signed by a Judge	30 days
*Adopted Child	• Adoption Documents & Birth Certificate	30 days
*Child Placed for Adoption	• Placement Documents & Birth Certificate	30 days
*Qualified Medical Support Order	• Notification from State Attorney General	As directed by AG's Order
*Other Medical Support Order directed to the City of Arlington	• Copy of Court Order to City of Arlington	30 days
A Child incapable of self-sustaining employment due to a mental or physical disability if the child was enrolled in the City medical plan the day before the child attains age 26.	• Attending Physician Statement	30 days
*Dependent must be less than 26 years old		

NOTE: IT IS THE RETIREE'S RESPONSIBILITY TO DROP COVERAGE FOR A DEPENDENT NO LONGER ELIGIBLE for a City plan. If a dependent becomes ineligible, an enrollment change is required within 30 days. Retirees are responsible for reimbursement of all benefit payments made or coverage provided for an ineligible dependent. If at any time an ineligible dependent is enrolled in coverage or remains enrolled in coverage when they do not meet the eligibility criteria described in this guide or the full Summary Plan Description, the retiree will be responsible for all IRS tax implications (including penalties assessed by the IRS) and must reimburse the City for all contributions made on behalf of the ineligible dependent. If you fail to make the coverage change within the required time frame, the dependent remains ineligible for benefits, however, your monthly contribution will not change for the remainder of the plan year. It will be your responsibility to drop the ineligible dependent during the next annual open enrollment to become effective January 1st of that next plan year.

IMPORTANT: You may not be enrolled as a Retiree and a dependent in any City of Arlington plan.

Dependent Verification

When you enroll for Retiree Benefits by completing the Retiree Benefit Election form or via the online enrollment system, you will attest that you understand the definitions for dependent eligibility and that only eligible dependents have been enrolled in any plan.

Annual Audit of Selected Retirees

Annually, we will conduct an audit requiring selected retirees to provide documentation proving eligibility of covered dependents. Those contacted will receive a list of acceptable documentation based upon the type of dependent enrolled. If sufficient documentation is not provided within a 30 day period, coverage will be dropped and/or denied. Providing dependent information that is false and inaccurate can result in termination of coverage and/or financial restitution. This process is intended to confirm that you have enrolled only qualifying family members under the terms of the benefit plans.

Retiree Payments

As a result of a growing retiree population and escalating healthcare costs, the City finds it necessary to establish guidelines regarding non-payment

of benefit contributions as well as checks that have been returned by the bank that were submitted to the City for benefit payments.

Retirees are notified of the monthly payment when they retire and each year prior to January 1. Benefit payments are due on the 1st of each month and must be paid in full on or before the due date. Payments may be made monthly, quarterly, or annually. If payments are not received in Finance by the 5th of the month, a 5% late fee will be imposed on each payment that is past due. A month's contribution and associated late fee must be paid in full no later than 60 days past the due date to avoid cancellation. If there are two payments past due, both month's premiums and associated late fees must be paid in full no later than 60 days past the first month's premium due date to avoid cancellation.

Benefit payments also become past due when a check that was sent in is returned by the bank. Returned checks will incur the City's returned check fee of $25. Payment must be made in full each month on the due date.

Retirees with past due premiums and associated late fees due to non-payment or returned checks will be subject to cancellation of their health, dental and vision benefits if payments and associated late fees remain unpaid for 60 days.

Past Due 30 days – First Notice will be sent to retiree.
Past Due 45 days – Second Notice will be sent to retiree by certified mail.
Past Due 60 days – Cancellation Notice will be sent to retiree by certified mail.

If all payments and/or late fees are not received in full within the 60 day time frame, notice will be given to Workforce Services to process a cancellation of the retiree's benefit coverage. Retirees who have had their coverage cancelled for late payment or non-payment **will NOT be eligible to reinstate their benefits**.

If you have questions, please contact the Retiree/ Payroll Clerk at 817-459-6300.

Retiree Personal Information Update!

It is the responsibility of all participants to notify the City of any changes in address, e-mail address and phone number. Please mail to:

City of Arlington
Workforce Services
PO Box 90231, MS 63-0790
Arlington, TX 76004-3231

RETIREES MUST BE ENROLLED IN A BENEFIT PLAN TO ALLOW ELIGIBLE DEPENDENT TO ENROLL.

Declining Coverage or Cancellation of Coverage

Retirees and their eligible dependents may drop medical coverage and re-enter the plan based on the following criteria:

- At any time during the year if the change is qualified as outlined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or
- During the annual open enrollment period with coverage becoming effective January 1 of the plan year following the annual open enrollment period.

The retiree will be eligible for the City contribution in place at the time of re-enrollment for themselves and their dependents based on their applicable years of service with the City. Retirees must be enrolled in the same coverage as their spouse or child. Surviving spouses may continue the medical coverage enrolled in at the time of a retiree's death. Coverage terminates when a surviving spouse remarries. A surviving spouse who drops or declines coverage for any reason will not have the option to enroll at a later date.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

IMPORTANT INFORMATION

Participants may not change plans due to a life event as a result of retirement, return from unpaid leave, birth of a child, marriage, divorce, etc. Example: January 1 you elect to enroll in the Plus Medical plan. You retire from the City effective March 31. If you continue medical coverage as a retiree, you must remain enrolled in the Plus Medical plan for the balance of the calendar year.

Dental Plans

The City's dental coverage is administered by MetLife Dental. You may choose one of three dental plans:

- A Dental Health Maintenance Organization (DHMO) plan that requires you to select an in-network provider before seeking dental services. Providers are located exclusively in Texas. If you move out of Texas, you must notify us within 30 days to drop coverage or change to one of the PPO plans.
- Two Preferred Provider Organization (PPO) dental plan options that allow you the freedom to select any dentist. However, in-network providers will typically charge a lower fee for services.

Refer to the Dental Plan Comparison Chart below and the coverage summaries included on the City website for the schedule of benefits and additional plan details. Call 1.800.942.0854 for assistance with selecting a dentist or to request a provider listing.

DENTAL PLAN COMPARISON:

Plan Feature	**DHMO Plan (In-Network dentist selection required)**	**Low PPO Plan (In- or Out-of-Network)**	**High PPO Plan (In- or Out-of-Network)**
Deductible (calendar year)	None	$50 per person/Maximum $150 ($50 x 3)	$50 per person/Maximum $150 ($50 x 3)
Preventive care: one visit every six months for a routine checkup, cleaning and polishing *	Plan pays 100% after $5.00 appointment co-pay for in-network dentist only.	Plan pays 80% of eligible dental fees. Deductible does not apply.	Plan pays 80% of eligible dental fees. Deductible does not apply.
Basic care: fillings *	You pay a fixed co-pay according to the plan schedule for in-network dentist only.	Plan pays 60% of eligible dental fees after deductible is met.	Plan pays 80% of eligible dental fees after deductible met.
Major care: bridges, dentures *	You pay a fixed co-pay according to the plan schedule for in-network dentist only.	Plan pays 50% of eligible dental fees after deductible is met. Waiting periods may apply.	Plan pays 50% of eligible dental fees after deductible met. Waiting periods may apply.
Maximum annual benefit	No limit	$750 per person	$1,500 per person
Orthodontic care	See fee schedule (adults & children under age 26)	No coverage	50% with a lifetime maximum of $1,000 (children under 19 only)
Implants	No coverage	Plan pays 50% of eligible fees	Plan pays 50% of eligible fees

* Refer to DENTAL RATE CHARTS, schedules and summary plan descriptions found on the City of Arlington website www.arlingtontx.gov or the MetLife Dental website at www.metlife.com.

Under Age 65 Medical Plan Options

IMPORTANT INFORMATION

Participants may not change plans due to a life event as a result of retirement, return from unpaid leave, birth of a child, marriage, divorce, etc... Example: January 1 you elect to enroll in the Plus Medical plan. You retire from the City effective March 31. If you continue medical coverage as a retiree, you must remain enrolled in the Plus Medical plan for the balance of the calendar year.

Life Event Coverage Level Changes for the Value Medical Plan

Before you enroll in the Value plan, you should be aware of how the deductible will work as a result of a coverage level change (Single to Family OR Family to Single) for the balance of the plan year. Here are some examples of what to expect:

Example 1: You and your spouse enroll in the Value plan effective January 1. From January through March your claims equal $500 and your spouse's claims equal $2,500 to meet the $3,000 Family deductible. You are now paying 10% of eligible expenses. Effective April 1, your spouse is Medicare eligible and enrolls in Medicare and an AARP supplement plan. Your coverage level now changes from Family to Single. You have claims equal to $500 of the $1,500 Single deductible. You will have to meet your additional $1,000 deductible before any benefits are paid. There are no claims reprocessed for which you have already received a benefit above the $3,000 Family deductible.

Example 2: You increase your coverage level from Single to Family due to your marriage. You have already met the $1,500 Single deductible. The Family deductible is $3,000. You will have to meet the additional deductible before any benefits are paid.

The City of Arlington offers three medical plan options through UnitedHealthcare's Choice Network of physicians. The covered services and the network of providers are identical. All plans provide **in-network benefits only. Services received out-of-network are the full responsibility of the retiree.**

Although a primary care physician is not required, you are encouraged to choose a primary care physician (PCP) from the UnitedHealthcare Choice network to coordinate your health care. Additionally, referrals are not necessary to see a specialist in the UnitedHealthcare Choice network.

1. Core Plan (Choice In-Network Providers/Facilities ONLY)

- $1,000 per person, $2,000 per family deductible
- Deductible must be paid before the plan will pay medical benefits (other than preventive care)
- Deductible is counted toward meeting the out-of-pocket maximum
- After the deductible has been met for the plan year, the plan pays co-insurance of 80% and participants are responsible for 20% of eligible expenses
- The co-insurance applies to all incurred medical plan covered services, whether at the physician's office, the emergency room, outpatient surgery, or hospital admissions.
- The maximum amount of co-insurance that you will pay on this plan is $5,000 per person or $10,000 per family
- The plan pays 100% of eligible preventive care services (not subject to meeting the deductible). Preventive services include services as defined by the United States Preventive Services Task Force. In 2013, birth control will be paid at 100% of eligible expenses.

2. Plus Plan (Choice In-Network Providers/Facilities ONLY)

- $750 per person, $1,500 per family deductible
- Deductible must be paid before the plan will begin to pay medical benefits other than preventive care)
- Deductible is counted toward meeting the out-of-pocket maximum
- After the deductible has been met for the plan year, the play pays co-insurance of 80% and participants are responsible for 20% of eligible expenses.
- The co-insurance applies to all incurred medical plan covered services, whether at the physician's office, the emergency room outpatient surgery, or hospital admissions.
- The maximum amount of co-insurance that you will pay on this plan is $5,000 per person or $10,000 per family.
- The plan pays 100% of eligible preventive care services and are not subject to meeting the deductible. Preventive services include services as defined by the United States Preventive Services Task Force. In 2013, birth control will be paid at 100% of eligible expenses.

When considering the Value, Core and Plus Plans, **it is important to remember that the participant is responsible for paying the deductible amount before any benefits will be paid toward medical care other than preventive care services.** The plan pays 100% of eligible preventive care services. These services include, but are not limited to well baby/child care, well woman care, and annual physicals.

3. Value Plan (Choice In-Network Providers/Facilities ONLY)

- The Plan deductibles are $1,500 for one person, $3,000 for more than one person.

IMPORTANT: Mid-year plan changes that reduce the coverage level from Family to Single may require the member to meet any portion of the Single deductible not already met by that member ($3,000 to $1,500).

- This plan qualifies as a High Deductible Health Plan (HDHP) as outlined by the Internal Revenue Code
- **The deductible applies toward the out-of-pocket maximum**
- Medical and prescription expenses are combined under this plan to meet the annual deductible
- After the deductible has been met for the plan year, the plan pays co-insurance of 90% and the participant is responsible for 10% of eligible medical and pharmacy expenses.
- **When enrolled for more than one person, the full family deductible amount of $3,000 must be met by one covered family member or a combination of covered family members. After the deductible has been met, eligible benefits are paid at the 90% level. See page 9 for details when this coverage level changes mid-year.**
- The co-insurance applies to both medical services and prescriptions.
- The maximum amount of co-insurance that you will pay on this plan is $5,000 for one person or $10,000 for more than one person. When enrolled for more than one person, the full family out-of-pocket amount of $10,000 must be met by one covered family member or a combination of covered family members before medical benefits are paid at the 100% level.
- The plan pays 100% of eligible preventive care services (not subject to meeting the deductible). These services are based on the United States Preventive Services Task Force guidelines. In 2013 birth control will be paid at 100% of eligible expenses.
- You may be eligible to open an individual Health Savings Bank Account (HSA). We encourage you to review IRS Publication 969 to determine if you are eligible to make contributions to an HAS bank account. Go to www.irs.gov before you enroll to review the IRS eligibility criteria.

Medicare Coverage:

If you or any of your family members are eligible for Medicare, covered by Medicare, or become eligible/ covered by Medicare, it is YOUR responsibility to notify Workforce Services immediately by providing a copy of the Medicare card. Typically the City's coverage for an active retiree (and their family members) will be the primary plan. However, coordination of benefits is determined by Medicare laws and there are situations when Medicare may become the primary coverage even when you are an active retiree. Medicare is typically the primary plan for retirees. Refer to www.medicare.gov for additional information regarding coordination of benefits with group health plans.

Pre-Existing Condition Exclusion Clause

There are no pre-existing conditions exclusions for dependent children or adults under any of the medical plans offered by the City of Arlington effective January 1, 2013..

Prescription Drug Plans

The prescription benefit is the same for both the Core and Plus plans - a 4-tier structure where you are responsible for a percentage of the total drug cost. **Typically**, Tier 1 will include generic or very common drugs, Tier 2 will include preferred name brand drugs, Tier 3 will include non-preferred name brand drugs, and Tier 4 will include specialty drugs.

Tier	Example Cost	RET Pays	% RET Cost	Health Plan Pays	Health Plan Cost
1	$ 30.00	15%	$ 4.50	85%	$25.50
2	$ 95.00	25%	$28.75	75%	$71.25
3	$200.00	40%	$80.00	60%	$120.00
4	$760.00	50%	$380	50%	$380.00

The prescription plan for the Core and Plus plans has a separate $2,000 out-of-pocket expense maximum per participant. The Plan pays 100% of a participant's eligible prescriptions for the remainder of the calendar year once the maximum is met. This $2,000 does not go toward meeting the Core or Plus medical plans deductible or annual out-of-pocket maximums.

SPECIALTY MEDICATIONS

Specialty medications are critical to improving the health and lives of individuals and are also some of the most expensive medications being used today. Specialty medications are typically more than $250.00 per prescription, in an injectible or oral form, treat rare or complex diseases and typically require additional clinical support for better health outcomes.

Under 65 Medical Plans Comparison

*ONLY IN-NETWORK COVERAGE PROVIDED UNDER THESE PLANS

	Value	Core	Plus
Annual Deductible	$1,500/$3,000 Single coverage/Spouse or Family	$1,000/$2,000	$750/$1,500
Co-insurance	10%	20%	20%
Out-Of- Pocket Maximum (Medical Plan Deductible counts toward out-of-pocket maximum)	$5,000/$10,000 Retiree/ Retiree+Family	$5,000/$10,000	$5,000/$10,000
Physician Office Visit	10% after deductible	20% after deductible	20% after deductible
Specialist Office Visit	10% after deductible	20% after deductible	20% after deductible
After Hours Office Visit	10% after deductible	20% after deductible	20% after deductible
Physical Exams	10% after deductible	20% after deductible	20% after deductible
Gynecological Exams	10% after deductible	20% after deductible	20% after deductible
Preventative Care: Plan pays 100%. Services must be coded by your provider as preventative typically include but are not limited to well baby/child care, well woman/man care, and annual physicals.			
In-Patient Hospital	10% after deductible	20% after deductible	20% after deductible
Emergency Room	10% after deductible	20% after deductible	20% after deductible
Urgent Care Facility	10% after deductible	20% after deductible	20% after deductible
Ambulance	10% after deductible	20% after deductible	20% after deductible
Outpatient Surgery	10% after deductible	20% after deductible	20% after deductible
Mental Health: Inpatient	10% after deductible	20% after deductible	20% after deductible
Outpatient	10% after deductible	20% after deductible	20% after deductible
Radiology/Anesthesiology/Pathology/ Lab Services	10% after deductible	20% after deductible	20% after deductible
Pharmacy (local and mail order)	10% after deductible	Each participant has to meet a separate $2,000 Out of Pocket Maximum then the City pays 100% for eligible prescriptions. This $2,000 does not count toward meeting your medical plan deductible or out of pocket maximum. Co-insurance by tier: Tier 1 = 15%, Tier 2 = 25%, Tier 3 = 40%, *Tier 4 = 50% *specialty pharmacy for Core and Plus plans.	
Contraceptives - Visit www.myuhc.com for a complete list of covered contraceptives	100% of eligible	100% of eligible	

This comparison of benefits is a basic summary for the medical/pharmacy plans available to you/your family. Refer to the Summary Plan Description or the Summary of Benefits and Coverage for the complete schedule of benefits located on the City website at www.arlingtontx.gov.

***NOTE:** All out-of-network charges are your responsibility. Therefore, if you utilize an out-of-network provider or facility, you will be responsible for 100% of those charges.

Vision Plans

You may elect vision coverage through EyeMed. The plan pays benefits for annual exams and corrective lenses. You pay co-pays for exams, and the plan pays for frames and lenses up to certain limits. Under this plan, you may use in-network or out-of-network vision care providers, but you receive greater benefits when you use in-network providers.

The plan will pay for contacts or eyeglass lenses once every 12 consecutive months and frames once every 24 consecutive months based on the schedule of benefits.

Refer to VISION RATE CHARTS, schedules and summary plan descriptions found on the City of Arlington website www.arlingtontx.gov.

Vision Care Services	**In-network Member Cost**	**Out-of-network Reimbursement**
Comprehensive vision exam (once every 12 months)	$10 co-payment	UP to $40
Standard lenses (once every 12 months)	$10 co-payment (Each pair of lenses purchased through a participating EyeMed provider includes scratch-resistant coating.)*	Single vision lenses up to $40 Bifocals up to $60 Trifocals up to $80 Lenticulars up to $80
Contact lenses (in lieu of eyeglasses once every 12 months)	$105 allowance*	Medically necessary up to $210. Elective up to $105
Standard frames (once every 24 months)	Most frames covered in full. May receive a $130 allowance on frames at retail chain providers, 20% off balance over $130 Contact EyeMed for network providers in your area.*	Up to $80
Refractive Eye Surgery for Lasik or PRK	Discount at participating providers only – for provider listing visit www.eyemedvisioncare.com	No benefit
*The above comparison is a summary only. Refer to the EyeMed schedule of benefits included on the City's website.		

Age 65+ Medical/Pharmacy Plans

Participants age 65 and over who wish to remain on a City of Arlington plan –must enroll in either the Medicare Advantage HMO Plan (previously Secure Horizons); or one of two AARP Medicare Supplement plan options (Plan K or F). Also, you must be enrolled in Medicare Part A & B and provide a copy of your Medicare card to Workforce Services.

The Medicare Advantage Plan offered is UnitedHealthcare Medicare Advantage HMO (previously Secure Horizons). The Medicare Advantage Plan combines Medicare Parts A & B and includes prescription drug coverage. Currently the UHC Medicare Advantage HMO plan offered by the City is only available to residents of Tarrant, Dallas, Denton, Johnson, Collin, Ellis, Rockwall, and Kaufman counties.

The City offers two Medicare Supplement Plans-AARP Plan K and AARP Plan F. You may enroll in Plan K or Plan F with or without Medicare Part D (pharmacy) coverage. AARP membership is required for the first year only if enrolling in an AARP Medicare supplement plan. United Healthcare will pay the membership fee for one year for new AARP memberships only.

NOTE: Individuals enrolled in the AARP Plan J option as of 12/31/09 may remain in the Plan J, however this option is not available to <u>new</u> enrollees.

The Centers for Medicare and Medicaid (CMS) allows enrollment in only **<u>one</u>** Medicare Part D Plan. Your enrollment in a City sponsored plan must be approved by CMS. Every Medicare eligible participant is required to provide the City with a copy of the front of their Medicare card to ensure accurate Medicare numbers are provided to CMS.

You may enroll in the United Healthcare Medicare Part D Pharmacy Plan through the City of Arlington or you may decline it and choose a privatePart D plan that is better suited to your pharmacy needs. If you attempt to enroll in more than one pharmacy plan, CMS will deny your coverage and will provide you notification that your request has been denied.

If you decline the UHC Medicare Part D Pharmacy Plan offered by the City, you must complete a decline form and submit it with a Retiree Benefit Election form.

Age 65+ retirees and their spouse must be enrolled in the same medical/pharmacy plan option. Split coverage is only allowed when one member (retiree or spouse) is over 65 and the other is under 65.

United Healthcare will mail a personalized AARP and/or UHC Medicare Advantage HMO plan enrollment kit to the home address of current participants approaching 65. You may request an enrollment kit by calling United Healthcare at the phone number listed on the back page of this guide. Enrollment requires that you complete the appropriate enrollment form -- AARP or UHC Medicare Advantage HMO -- and mail it directly to them in the envelope provided. You also must complete a Retiree Benefit Election Form and provide a copy of your Medicare card to Workforce Services at the address provided on the Retiree Benefit Election Form. For more information on choosing a Medicare Supplement Plan, visit the Medicare website at www.medicare.gov.

IMPORTANT: All medical and pharmacy coverage in any of the pre-65 plans will end on the last day of the month prior to the month you become 65.

For rate charts, schedules and summary plan descriptions of the Age 65+ Plans, visit the City website at www.arlingtontx.gov. Click the CITY PROGRAMS/SERVICES drop-down box on the upper left side, select RETIREES and then select CITY BENEFITS.

Health Savings Accounts

If you enroll in the Value Medical Plan, then you may be eligible, based on current IRS regulations, to open a Health Savings Account (HSA) with Optum Health Bank, a United HealthGroup Bank. The Value Plan is considered a high deductible health plan under current IRS regulations.

What are the benefits of an HSA?

- You can claim a tax deduction for contributions you, or someone other than the City, make to your HSA even if you do not itemize your deductions on Form 1040.
- The contributions remain in your account from year to year until you use them.
- The interest or other earnings on the assets in the account are tax free.
- Distributions may be tax free if you pay qualified medical expenses (IRS Publication 969).

Do I Qualify for an HSA Account?

It is very important that you verify your eligibility to open an HSA account. The first step to determining if you are eligible is to answer the following questions:

- Are you enrolled in the City's Value Plan (a high deductible health plan)?
- If enrolled in the City's Value Plan, Is this the only medical plan you are enrolled in? (This does not apply to specific injury insurance and accident, disability, dental care, vision care and/or long term care.)
- Can you or your covered family members be claimed as a dependent on someone else's tax return?
- Are you or a covered dependent eligible for or enrolled in Medicare?
- Are you currently enrolled in an FSA Health account? (May be enrolled in a limited purpose FSA account for dental and vision expenses only.)
- Do you qualify to make a claim from a previous FSA Health account balance due to the IRS allowed 2 -1/2 month extension provision? Example: City of Arlington has this provision. If you have or will have any balance remaining as of the 31st of December each plan year, you would not qualify to open an HSA individual bank account until the 1st of April in the year you enroll in the Value Plan.

For questions regarding HSA plan enrollment and/or eligibility, review IRS Publication 969 or contact your tax advisor.

When a participant meets the IRS eligibility requirements, he/she may choose to open an HSA. Optum Health Bank is the exclusive HSA administrator and the City of Arlington will pay $3.00 of the monthly administrative fees associated with the account while the participant is enrolled in the high deductible Value Plan.

The bank account should be opened and contributions may begin the first full month after coverage begins on the high deductible health plan (Value Plan).

How much may I contribute to the HSA?

Contribution levels change each year. The Internal Revenue Code also allows a catch-up provision for participants who attain age 55 any time in 2013.

US Patriot Act Screening Process

In 2001, in response to 911 terrorist attacks, the Patriot Act was created to help the government fight the funding of terrorism and money laundering activities. Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens a bank account. The act requires banks to obtain and verify a customer's name, address, date of birth and identification number (Social Security number) before allowing an account to accept contributions. Optum maintains a secured database, and all applicants requesting an HSA must provide this information to request an individual bank account. Optum will notify the participant when the account has been approved and contributions may then begin the first full pay period after the month of approval.

The account belongs to the participant and all annual reporting is the sole responsibility of the participant. Account holders will be required to file Form 8889 with their 1040 annually. Optum provides monthly on-line statements at www.myuhc.com, an annual form 1099SA by January 31 each year, and an annual form 5498SA by May 31 each year.

HSA Qualified Expenses

Refer to IRS Publication 969 for those expenses qualified for payment with contributions to your HSA account.

Refer to the City's website www.arlingtontx.gov, the IRS website www.irs.gov, Publication 969 or your tax advisor for additional HSA information.

CARE24 Services

The City of Arlington provides Core, Plus and Value medical plan participants and their family members access to the United Healthcare Care24 services. Care24 offers access to a wide range of health and well-being information – seven days a week, 24 hours a day. Using one toll-free phone number, you may speak with registered nurses and master's level counselors who can help with almost any problem ranging from medical and family matters to personal legal, financial, and emotional needs.

When you call the same number, you can listen to audio messages on more than 1,100 health and well-being topics. If face-to-face resources are more appropriate for your situation, a Care24 representative may refer you to local, in-person support. Counselors also may refer you to a wide range of national and community resources.

Care24 nurses and counselors are available 24 hours a day, 7 days a week. Call 1-888-887-4114.

Life Events/Family Status Change

Life Changes Require Health Choices... Know Your Benefit Options

Knowing your benefit options means knowing the basics about health care law so you can protect yourself and your dependents. And it means finding out now about some common sense steps you can take to make sure you have the level of health care coverage you need at every stage of your life.

Marriage

What You Need to Know: Get all the details on your spouse's plan, and be sure you understand how it works. You'll want to know the amounts of any deductibles or co-pays you will be required to pay and what you will pay for premiums.

Under the Health Insurance Portability and Accountability Act (HIPAA), you may be entitled to add yourself, a new spouse, and children to your employer's plan or to your spouse's employer's plan under a special enrollment period.

What You Need to Do: To qualify for the special enrollment period, you must notify the plan and request special enrollment for everyone enrolling within 30 days of your marriage. We require that the notice be in writing, and that is usually the safest course of action anyway.

If your spouse has health coverage available, compare the health benefits, cost, and options under both plans, then decide which one works best for you.

Pregnancy, Childbirth, and Adoption

What You Need to Know: HIPAA places limits on the amount of time a preexisting condition exclusion period may apply. In addition, health care plans cannot consider pregnancy a preexisting condition, even if the woman did not have previous coverage.

Birth and adoption (including placement for adoption) may trigger a special enrollment period during which you, your spouse, and new dependents can enroll.

What You Need to Do: You must notify your plan and request special enrollment within 30 days of your child's birth, adoption, or placement for adoption. The child's enrollment will be treated as occurring on the date of the birth, adoption, or placement for adoption. We require that the notice be in writing, and that is usually the safest course of action anyway.

When Your Child is No Longer a Dependent

What You Need to Know: Once your child "ages out" under your health care plan's rules, the child may be eligible to purchase temporary extended health care coverage for up to 36 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

What You Need to Do: Once your covered child is no longer a dependent, notify your employer in writing within 60 days. In turn, your plan should notify your child of his or her right to extend health care benefits under COBRA. Your child will have 60 days from the date the notice was sent to elect COBRA coverage. The cost will be higher, since the total plan cost will be included as the City will no longer pay a portion. COBRA costs are posted on the Workforce Services portal under the category of COBRA.

Death, Legal Separation, or Divorce

What You Need to Know: When a retiree covered under an employer-sponsored health plan dies, or divorces, the covered spouse and dependent children may be eligible to purchase temporary extended health coverage for up to 36 months. The cost will be higher, since the total plan cost will be included as the City will no longer pay a portion. COBRA costs are posted on the Workforce Services portal under the category of COBRA.

If the spouse losing coverage under the City plan has a health plan available through his or her employer, the spouse and any dependents may be eligible to obtain coverage through special enrollment with their employer.

If the covered retiree dies or in the event of a divorce, the plan should notify the covered spouse and dependent children of their right to purchase extended health care coverage under COBRA. Most plans require eligible individuals to make their COBRA election of coverage within 60 days of the plan's notice.

What You Need to Do: Should the retiree who is covered by the health care plan die, the employer must notify the healthcare plans within 30 days. If there is a divorce or legal separation, the covered employee, spouse, or dependent children must notify the plan in writing within 60 days. In case of death of the covered retiree or divorce the plan will then notify the eligible spouse and dependent children who would lose coverage under the plan of their right to purchase temporary extended health care coverage. Enrollment is required within 60 days of the COBRA notice date.

If the spouse losing coverage under the plan has a health plan available through his or her employer, the spouse and dependent children may be eligible for a special enrollment under that plan. To qualify, the spouse must notify that plan and request special enrollment within 30 days of the loss of coverage.

Summary of COBRA Qualifying Events, Qualified Beneficiaries, and Maximum Periods of Continuation Coverage

The following chart shows the specific qualifying events, the qualified beneficiaries who are entitled to elect continuation coverage, and the maximum period of continuation coverage that must be offered, based on the type of qualifying event. Note that an event is a qualifying event only if it would cause the qualified beneficiary to lose coverage under the plan.

COBRA Qualifying Event	Qualified Beneficiaries	Maximum Period of Continuation Coverage
Termination (for reasons other than gross misconduct), reduction in hours of employment (FT to PT), or unpaid leaves	Employee Spouse Dependent Child	18 months(2)
Enrollment in Medicare	Spouse Dependent Child	36 months
Divorce or legal separation	Spouse Dependent Child	36 months
Death	Spouse Dependent Child	36 months
Loss of "dependent child" status under the plan	Dependent Child	36 months

LIFE EVENTS

You may be allowed to change your coverage level during the plan year due to the loss of other coverage, or for one of the following reasons:

- You marry or divorce;
- You gain a dependent due to birth, adoption, placement for adoption, eligibility under a Qualified Medical Child Support Order, legal guardianship, or lose a dependent due to ineligibility or death;
- You or your spouse obtains or loses a job which changes eligibility for coverage;
- You or your spouse experiences a significant change in employment status (for example, going from full-time to part-time) which changes eligibility for coverage;
- Your child is no longer eligible because of the plan's limiting age; or
- You or your spouse take or return from an unpaid leave of absence that affects coverage.

YOUR SPECIAL ENROLLMENT RIGHTS

You, your spouse, or your children may be entitled to enroll in the medical, dental and vision plans at times other than annual open enrollment. Generally, you may enroll in these plans when:

- Other coverage ends because you or your dependents are no longer eligible;
- You or your dependent exhaust COBRA coverage under another employer's plan;
- You gain a dependent, you marry, have a new child by birth or adoption, or a child is placed with you for adoption;
- The employer sponsoring the other coverage is no longer making contributions toward the cost of coverage.

* If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance program (CHIP) coverage and you request enrollment **within 60 days** after that coverage ends; or

*If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and your request enrollment **within 60 days** after the determination of eligibility for such assistance.

Note: The 60 day period for requesting enrollment applies only in these last two listed circumstances relat-ing to Medicaid and state CHIP. As described above, a **30 day period** applies to most special enrollments. **Please forward all required** documentation to the Workforce Services department.

Proof Requirement – Documentation for a mid-year benefit plan change due to a life event must be provided to Workforce Services **within 30 days of the event.** Typical documentation would include the name and date of birth of the family member who has either gained or lost coverage and the effective date of the gain or loss of coverage. Document examples include, but are not limited to COBRA notices, Certificate of Healthcare Coverage forms, employer letterhead outlining the details including the date of gain or loss of specific coverage.

Warning: *Any intentional false statement in your enrollment or willful misrepresentation relative thereto is a violation of City policy subject to termination of coverage and/or financial restitution.*

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance.**

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments.**

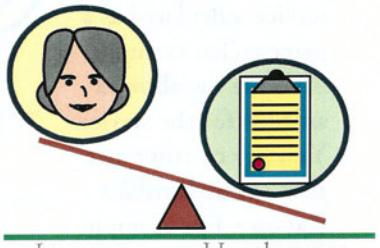
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit


(See page 4 for a detailed example.)

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

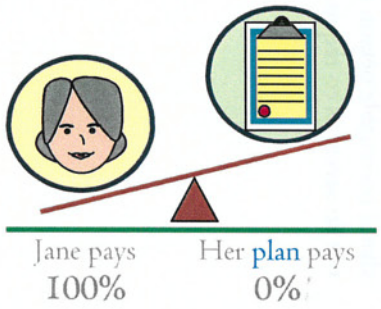
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

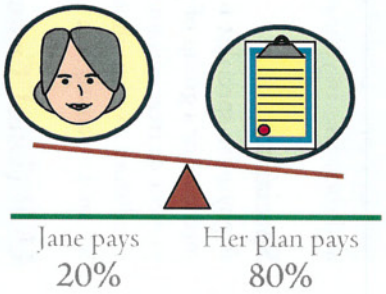


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

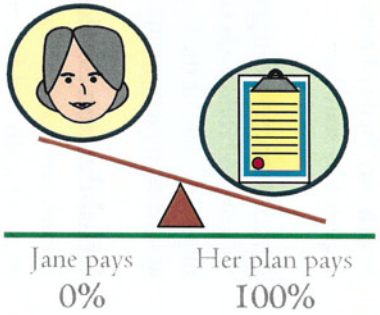


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

GENERAL NOTICE

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under The City of Arlington Texas group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It may also become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, (Examples: status change from FT to PT, unpaid leave of absence (other than up to 12 weeks when on approved Family Medical leave), or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a bankruptcy proceeding under title 11 of the United States Code can be a qualifying event. If a proceeding bankruptcy is filed with respect to The City of Arlington Texas, and that bankruptcy results in loss of coverage for any retired employee under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become qualified beneficiaries if bankruptcy results in loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction in hours of employment, death of the employee, commencement of a bankruptcy proceeding with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: City of Arlington Texas, Attention: Workforce Services, 101 S. Mesquite – Suite 790, PO Box 90231, MS 63-0790, Arlington, TX 76004-3231. If the qualifying event is divorce you will need to provide a copy of the executed decree as documentation of the date of the divorce or legal separation.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months (36 months minus 8 months) after the date of the qualifying event. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family might be entitled to receive an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the Plan Administrator of the second qualifying event within 60 days of a second qualifying event. Notice must be sent to: City of Arlington Texas, Attention: Workforce Services, 101 S. Mesquite – Suite 790, PO Box .90231, MS 63-0790, Arlington, TX 76004-3231. Please include a copy of your Social Security Determination letter.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension can become available to the spouse and dependent children receiving coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if this second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event occurred. In all of these cases, you must notify the Plan Administrator of the second qualifying event within 60 days of this second qualifying event. Notice must be sent to: City of Arlington Texas, Attention: Workforce Services, 101 S. Mesquite – Suite 790, PO Box 90231, MS 63-0790, Arlington, TX 76004-3231. Please include a copy of the death certificate, Medicare card(s) or divorce/legal separation decree as applicable.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contacts identified in the next section of this notice. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep, for your records, a copy of any notices you send to the Plan Administrator.

Plan Contact Information

The Plan Administrator is City of Arlington Texas 817.459.6869. The Plan Administrator is responsible for administering COBRA continuation coverage. The City of Arlington, Texas has contracted with United Healthcare to administer COBRA continuation coverage. All COBRA elections are sent directly to United Healthcare. Questions regarding COBRA elections and payments may be directed to United Healthcare's Customer Service 1.866.747.0048.

Update October 20, 2012

Important Notice from the City of Arlington About Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Arlington and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Arlington has determined that the prescription drug coverage offered by the United Healthcare Medco Pharmacy Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because this coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from Oc tober 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you are an active employee or a dependent of an active employee eligible to join a Medicare drug plan and you enroll in a Medicare drug plan, your Medco Pharmacy Plan coverage will end. Active employees and/or their dependents eligible for Medicare are not required to enroll in another Medicare Part D pharmacy plan and may remain in the Medco Pharmacy Plan only if not enrolled in a Medicare part D plan. For those active employees who elect Part D coverage, the city's Medco Pharmacy Plan will end for the employee and all covered dependents. The City's Medco Pharmacy plan does provide creditable pharmacy coverage.

Retirees and/or their dependents eligible for Medicare AND age 65 are not required to enroll in the UnitedHealthcare Medicare Part D pharmacy plan. However, pharmacy coverage ends in the Medco Pharmacy Plan upon attainment of age 65. The City offers the UnitedHealthcare Medicare Part D plan as a post 65 pharmacy option. Pre-65 retirees and/or dependents not eligible for Medicare may enroll in the Medco Pharmacy Plan.

If you do decide to join a Medicare drug plan and drop your current Medco Pharmacy plan through the City of Arlington, be aware that you and your dependents will not be able to get this coverage back.

NOTE: See the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/ options available to Medicare eligible individuals that are eligible for Medicare Part D.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Arlington and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information or call United Healthcare at 1.866.844.4867 regarding your United Healthcare Medco Pharmacy Plan. NOTE: You'll get this notice each year. You will also get it before the next open enrollment period when you can join a Medicare drug plan and if this coverage through the City's Medco Pharmacy Plan changes. You may view this notice on the City's website located at www.arlingtontx.gov. (Refer to Retirees / City Benefits) You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- ❑ Visit www.medicare.gov
- ❑ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- ❑ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 09/21/2011
Name of Entity/Sender: City of Arlington
Contact--Position/Office:
Workforce Services
Address: PO Box 90231
MS 63-0790
Arlington, TX
76004-3231
Phone Number: 817.459.6869

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS Form 10182-CC Updated October 5, 2011

REQUIRED NOTICE: UnitedHealthcare Annual Rights and Resource Disclosure Notice

Visit www.myuhc.com/uhcrights to view the Annual Rights and Resource Disclosure Notice. This document will inform you about:

- Finding a network physician or hospital
- Obtaining routine, preventive and specialty care; urgent, ER and hospital care; after-hours, out-of-state/area and behavioral health care
- Notification requirements and medical services, financial incentives and evaluation of new technology
- Case and Disease Specific Management
- Benefit coverage, exclusions, restrictions, and costs of care; Pharmacy procedures and benefits
- Looking up claims/Obtaining an ID card
- How to voice a complaint or submit an appeal
- Quality improvement program results
- Your rights and responsibilities as a member
- Women's Health and Cancer Rights Act/ Newborns' and Mothers' Health Protection Act
- Notice of Privacy Practices
- Language assistance services

The City's plan also includes behavioral health benefits for the following participants:

- Active/Retiree/COBRA participants enrolled in the Value, Core or Plus medical plans but choose plans with the City of Arlington
- Active employees eligible for the Value, Core or Plus medical plans but choose to waive this coverage through the City
- COBRA participants enrolled in EAP - Employee Assistance Program

Additional information about United Behavioral Health is available at: www.liveandworkwell.com/WellnessMatters. To request a paper copy, call the toll-free member phone number on your ID card.

Log into www.myuhc.com/uhcrights to view the Annual Rights & Resource Disclosure. If you do not have internet access, contact Workforce Services 817-459-6869 to request a paper copy be mailed to your home address.

Reviewed 10/20/12

Health Care Reform Required Notice

Effective January 1, 2011, under the Patient Protection and Affordable Care Act (the Affordable Care Act);, City of Arlington is required to provide the following notice and disclosure regarding primary care providers (PCP) and pediatricians as PCP for a child. Also included in the required notices below is information regarding OB/GYN providers, prior authorization and referral information.

Designation of a Primary Care Provider

The City of Arlington health plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the UnitedHealthCare network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact UnitedHealthCare at the phone number included on your medical card or complete a provider search on www.myuhc.com.

For children, you may designate a pediatrician as the primary care provider.

Access to Obstetrical or Gynecological Care

You do not need prior authorization from United Healthcare or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the UHC network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participant health care professions who specializes in obstetrics or gynecology, contact United Healthcare at the phone number included on your medical card or complete a provider search on www.myuhc.com.

Effective January 1, 2011, under the Patient Protection and Affordable Care Act (the Affordable Care Act), the City of Arlington may not offer a medical plan that includes an individual lifetime maximum benefit. The City of Arlington health (Core/

Plus/ Value) plans do not include individual lifetime maximum benefits. However, we are required to provide you with the following Notice:

Lifetime Limit No Longer Applies and Enrollment Opportunity Notification

The lifetime limit on the dollar value of benefits under the City of Arlington medical plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this noticeFor more information contact Workforce Services to request re-enrollment.

Effective January 1, 2011, under the Patient Protection and Affordable Care Act (the Affordable Care Act), the City of Arlington will extend dependent coverage for employee/retiree dependents up until they are 26. The City's previous policy included dependents up until they are 25. Following is the required Notice regarding this change:

Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before the attainment of age 26 are eligible to enroll in a City of Arlington medical, dental and/or vision plan. Individuals may request enrollment for such children during the annual open enrollment period. Enrollment will be effective January 1st, 2013. For more information contact Workforce Services 817.459.6869.

Find additional information about the Affordable Care Act at www.dol.gov/ebsa/healthreform/

Other Required Notices

Maternity Coverage

For maternity stays, in accordance with federal law, the plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean delivery. However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a cesarean delivery).

Pre-existing Condition Limitation

Effective Janaury 1, 2013, the City's medical plans no longer include a pre-existing condition exclusion for adults or children.

Women's Health and Cancer Rights

On October 21, 1998, Congress passed a bill called the Women's Health and Cancer Rights Act. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical complications during all stages of mastectomy, including lymphedemas

In addition, the plan may not:

- interfere with a woman's rights under the plan to avoid these requirements, or
- offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law. However, he plan may apply deductibles and copays consistent with other coverage provided by the plan. If you have questions about the current plan coverage, please contact UnitedHealthCare by calling the phone number provided on your Medical ID Card.

CHIPRA Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employ-er-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid Website: www.medicaid.alabama.gov Phone: 1-855-692-5447	COLORADO – Medicaid Medicaid Website: www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA - Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	FLORIDA – Medicaid Website: www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
ARIZONA - CHIP Website: www.azahcccs.gov/applicants/ Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	GEORGIA – Medicaid Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	MONTANA – Medicaid Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA - Medicaid Website: www.in.gov/fssa Phone: 1-800-889-9949	NEBRASKA – Medicaid Website: www.accessnebraska.ne.gov Phone: 1-800-383-4278
IOWA - Medicaid Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	NEVADA - Medicaid Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS - Medicaid Website: https://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	NEW HAMPSHIRE – Medicaid Website: www.dhhs.nh.gov/oii/documents.hippahp.pdf Phone: 603-271-5218

KENTUCKY - Medicaid Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	NEW JERSEY – Medicaid and CHIP Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA - Medicaid Website: www.lahipp.dhh.louisiana.gov Phone: 1-866-695-2447	
MAINE - Medicaid Website: www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY: 1-800-977-6741	NEW YORK – Medicaid Website: www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP Website: www.mass.gov/MassHealth Phone: 1-800-462-1120	NORTH CAROLINA – Medicaid Website: www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid Website: www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 800-657-3629	NORTH DAKOTA – Medicaid Website: www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI - Medicaid Website: www.dss.mo.gov/mhd/index.htm Phone: 573-751-2005	UTAH – Medicaid and CHIP Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OKLAHOMA – Medicaid and CHIP Website: www.insureoklahoma.org Phone: 1-888-365-3742	VERMONT – Medicaid Website: http://greenmountaincare.org/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP Website: www.oregonhealthykids.gov http://hijossaludablesoregon.gov Phone: 1-877-314-5678	VIRGINIA – Medicaid and CHIP Medicaid Website: www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA - Medicaid Website: www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	WASHINGTON – Medicaid Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND - Medicaid Website: www.ohhs.ri.gov Phone: 401-462-5300	WEST VIRGINIA – Medicaid Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH CAROLINA – Medicaid Website: www.scdhhs.gov Phone: 1-888-549-0820	WISCONSIN – Medicaid Website: www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
SOUTH DAKOTA – Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059	WYOMING - Medicaid Website: www.health.wyo.gov/healthcarefin/equalitycare Telephone: 307-777-7531
TEXAS - Medicaid Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)
Ext. 61565

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
Error! Hyperlink reference not valid.1-877-267-2323,

OMB Control Number 1210-0137 (expires 09/30/2013)

Retiree Important Contacts

Workforce Services Department
(enrollment and coverage questions)
City Tower, Seventh Floor
101 S. Mesquite St.., Suite 790 • 817-459-6869

Financial Services Department
(billing and payment questions)
City Tower, Eighth Floor
817-459-6263

www.arlingtontx.gov

Vendor/Plan	Member Service Phone Number	Website
United Healthcare (Medical/Pharmacy) **Group #702632** Core & Plus Plans Value Plan (Definity)	 1-866-633-2446 1-866-314-0335	www.myuhc.com
AARP HealthCare Options **Group #000682** Pre-Enrollment Questions Post-Enrollment Customer Service	 1-800-392-7537 1-800-523-5800	www.aarphealthcareoptions.com
UHC Medicare Advantage HMO **Group #45018411** Pre-Enrollment Questions Post-Enrollment Customer Service	 1-800-610-2660 1-888-867-5548	www.uhcretiree.com
UHC Medicare Part D Rx **Group #328** Pre-Enrollment Questions Post-Enrollment Customer Service	 1-888-556-6648 1-888-867-5562	www.unitedmedicarerx.com
Met Life (Dental) **Group #0146053** Dental DHMO SGX245-TX Plan Options PPO	 1-800-880-1800 1-800-942-0854	www.metlife.com/mybenefits
EyeMed (Vision) Select Network **Group #9795691** Pre-Enrollment Questions Post-Enrollment Customer Service	 1-866-299-1358 1-866-723-0514	www.eyemedvisioncare.com
United Healthcare OptumHealth Bank (Health Savings Account)	 1-800-791-9361	www.myuhc.com
United Healthcare Care 24 Customer Service	 1-888-887-4114	www.myuhc.com
Texas Municipal Retirement System (TMRS) Customer Service	 1-800-924-8677	www.tmrs.com
ICMA-RC Customer Service	 1-800-669-7400	www.icmarc.com
Medicare	1-800-633-4227	www.medicare.gov
Social Security Administration	1-800-772-1213	www.socialsecurity.gov